STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING _____ B. WING _____	R 07/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	**1332 WATERFORD CIR GOSHEN, IN 46526**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Certification and State Licensure Survey completed on 5-19-14. This visit was in conjunction with a PSR to Investigation of Complaint #IN00146141 completed on 4-30-14. Survey dates: July 7, 8, 9, 19 and 11, 2014 Facility number: 011150 Provider number: 155760 AIM number : 200831020 Survey Team: Debora Kammeyer, RN, TC Lora Swanson, RN Census bed type: SNF: 40 SNF/NF: 20 Total: 60 Census payor type: Medicare: 21 Medicaid: 17 Other: 22 Total: 60 Maples at Waterford Crossing Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the Recertification and State Licensure Survey. Quality Review completed on July 14, 2014, by Brenda Meredith, R.N.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.